Department of Health and Human Services
Health Care Financing Administration
Operational Policy Letter #82
OPL99.082

Date: February 11, 1999

Subject: The Notice of Discharge & Medicare Appeal Rights (NODMAR)
(Formerly known as the Notice of Noncoverage--NONC)
MODEL LANGUAGE

The Health Care Financing Administration (HCFA) has been undergoing discussions with regard to our current policies concerning the Notice of Noncoverage (NONC) and the Important Message from Medicare which are currently in use. We understand and realize that there are still many unanswered questions regarding proposed changes to our policies for these notices (e.g. timing, staffing difficulties, etc.). We want you to know that we are committed to addressing all of those concerns and questions before making any changes to the current requirements for the issuance of these notices.

In the meantime, however, we have been receiving feedback from interested parties that the language contained in the current NONC is confusing to beneficiaries enrolled in Medicare managed care plans. In addition, the many variations of this notice have been reported to impose administrative burdens on both health plans and hospitals. Therefore, after consultation with beneficiary, managed care plan, and provider communities, we have revised the model language for the NONC and have changed its name to reflect a more "beneficiary-friendly" notice.

The Notice of Discharge and Medicare Appeal Rights (NODMAR), formerly known as the NONC, is designed to inform Medicare enrollees, in a more streamlined and accurate manner, of their rights when they have received a hospital inpatient discharge decision. The NODMAR (Attachment A) meets the notice requirements set forth in the existing Medicare regulations at 42 CFR 417.440(f) and the Medicare+Choice regulations at 42 CFR 422.620(c). You may use this model language or develop your own, but any NODMAR must include (1) the reason why inpatient care is no longer needed; (2) the effective date of the enrollee's risk of financial liability; and (3) the enrollee's appeal rights. Lastly, all NODMARs must be approved by your HCFA Regional Office plan manager.

In the near future, we will submit the model NODMAR to consumer testing to ensure that enrollees are able to understand their rights and how to exercise them when necessary. Upon completion of this testing with beneficiaries, HCFA intends to develop this model language into a standardized NODMAR form and proceed with the OMB clearance process.

We will keep you informed of, and involved in, all discussions as we continue to evaluate the feasibility of both notices and their impact on the beneficiary, managed care plan, and provider communities.

Attachment

Contact: HCFA Regional Office Managed Care Staff

This OPL was prepared by Beneficiary Membership Administration Group, Center for Beneficiary Services

Attachment A

NOTICE OF DISCHARGE & MEDICARE APPEAL RIGHTS

Enrollee's Name: Date of Notice:
Health Insurance Claim (HIC) Number: Admission Date:
Attending Physician: Discharge Date:
Hospital: Health Plan:

YOUR IMMEDIATE ATTENTION IS REQUIRED

Your doctor has reviewed your medical condition and has determined that you can be discharged from the Hospital because: [check one]

_____You no longer require inpatient hospital care.
_____You can safely get any medical care you need in another setting.
_____Other_____.

[Fill in details.]

This also means that, if you stay in the hospital, it is likely that your hospital charges for [*specify date of first noncovered day*], and thereafter will not be covered by your Health Plan.

The Hospital has developed a discharge plan which explains any follow-up care or medications you need. If you have questions about this follow-up care, you should discuss them with your doctor. If you have not received a discharge plan and wish to do so, please contact your nurse, social worker or doctor .

If you agree with your doctor's discharge decision, you can either read further to learn more about your appeal rights, or you can skip to the end of this notice and sign to show that you have received this notice.

However, if you disagree with your Doctor's discharge decision, Medicare gives you the right to appeal. In that case, please continue reading to learn how to appeal a discharge decision, what happens when you appeal, and how much money you may owe.

IF YOU THINK YOU'RE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON, REQUEST AN IMMEDIATE REVIEW

HOW DO YOU GET AN IMMEDIATE REVIEW?

- 1.The *[Name of PRO*] is the name of the Peer Review Organization -- sometimes called a PRO-- authorized by Medicare to review the Hospital care provided to Medicare patients. **You or your authorized representative, attorney, or court appointed guardian** must contact the PRO by telephone or in writing: *[Name, address, telephone and fax number of the PRO*]. If you file a written request, please write, "**I want an immediate review**".

- 2. **Your request must be made no later than noon of the first working day after you receive this notice.**

- 3. The PRO will make a decision within one full working day after it receives your request, your medical records, and any other information it needs to make a decision.

- 4. While you remain in the Hospital, your Health Plan will continue to be responsible for paying the costs of your stay until noon of the calendar day following the day the PRO notifies you of its official Medicare coverage decision.

WHAT IF THE PRO AGREES WITH YOUR DOCTOR'S DISCHARGE DECISION?

- If the PRO agrees, you will be responsible for paying the cost of your Hospital stay beginning at noon of the calendar day following the day the PRO notifies you of its Medicare coverage decision .

WHAT IF THE PRO DISAGREES WITH YOUR DOCTOR'S DISCHARGE DECISION?

- You will not be responsible for paying the cost of your additional Hospital days, except for certain convenience services or items not covered by your Health Plan.

WHAT IF YOU DON'T REQUEST AN IMMEDIATE REVIEW?

- If you **remain** in the Hospital and **do not** request an immediate review by the PRO, **you** may be financially responsible for the cost of many of the services you receive beginning [*specify date of first noncovered day].*

- If you **leave** before [*specify date of first noncovered day*], you will not be responsible for the cost of care. As with all hospitalizations, you may have to pay for certain convenience services or items not covered by your Health Plan.

WHAT IF YOU ARE LATE OR MISS THE DEADLINE TO FILE FOR AN IMMEDIATE REVIEW?

- If you are late or miss the noon deadline to file for an immediate review by your PRO, you may still request an expedited (fast) appeal from your Health Plan. A "fast" appeal

means your Health Plan will have to review your request within 72 hours. However, ***you will not***

have automatic financial protection during the course of your appeal. This means you could be responsible for paying the costs of your Hospital stay beginning *[specify date of first noncovered day]*.

HOW DO YOU REQUEST A FAST APPEAL?

You may call or fax your request to your Health Plan:

Stamp or Print Here Name of Health Plan Address Phone # and Fax #

- If you filed a request for immediate PRO review but were late in filing the request, the PRO will forward your request to your Health Plan as a request for a fast appeal.

- If you're filing a written request, please write, "I want a fast appeal."

- If you or any doctor asks your Health Plan to give you a fast appeal, your Health Plan must process your appeal within 72 hours of your request.

- Your Health Plan may take up to 14 extra calendar days to make a decision if you request an extension or if your Health Plan can justify how the extra days will benefit you. For example, you should request an extension if you believe that you or your Health Plan need more time to gather additional medical information. Keep in mind that you may end up paying for this extended hospital stay.

Please sign to let us know you have received this notice of discharge and appeal rights. By signing this notice, you do not give up your right to appeal this discharge.

_____ _____

Signature of Medicare Enrollee or Authorized Representative Date

cc: [*Health Plan*]